

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DATA

OSHDP Use Only

PM Date: _____

Agent: _____

DESIGNATED AGENT TRANSMITTAL FORM

Agent's Name: _____
Contact Person: _____ Title: _____
Address: _____
Phone No: () _____ Ext: _____
E-mail _____

DISKETTE

☐ 3½" Diskette

☐ CD-ROM

Filename: _____

FACILITY NAME	FAC. ID NO	DATA TYPE	REPORT PERIOD BEGIN	REPORT PERIOD END	TOTAL NO OF RECORDS
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____